KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

IMPRINT AREA

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize:

Name of Disclosing Party

Address

City State ZIP

To disclose to:

Name of Recipient

Address

City State ZIP

If requesting your own records for yourself, specify facilities: _____

Records and information pertaining to:

Name of Member/Patient (List Other Names Used) | Medical Record Number | Date of Birth

Address | Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date).

REVOCATION: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☐ **MEDICAL INFORMATION** _____ (Initial)
- ☐ **PSYCHIATRIC INFORMATION**
- ☐ **DRUG/ALCOHOL INFORMATION**
- ☐ **RESULTS OF AN HIV TEST**
- ☐ **GENETIC RECORDS**

Signature Date

Signature Date

Signature Date

Signature Date

Specify the records to be disclosed: _____

The recipient may use the health information authorized on this form for the following purposes:

A copy of this authorization is as valid as the original.

Member/Patient has a right to a copy of this authorization.

Date | Signature | If Signed by Other than Member/Patient, Indicate Relationship

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Southern California Permanente Medical Group

IMPRINT KAISER PERMANENTE ID CARD HERE

AUTHORIZATION FOR RELEASE AND / OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM**:

Name of Health Care Provider

Name of Medical Office/Hospital

Street Address

City, State and Zip Code

Please **SEND** Medical Information **TO**:

Name of Person or Entity to Receive Information

Title (Physician, Therapist, Attorney)

Street Address

City, State and Zip Code

I hereby authorize _____ to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and / or disclose records and information regarding:

Name of Patient (List Other Names Used) | Medical Record Number | Date of Birth

Address | City | State | Zip Code | ( ) Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until _____(*enter date*) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:

Check the box and initial which type of information is to be released and / or disclosed:

- ❑ **General Medical Information** *(from_____ to _____)*
- ❑ **Information Regarding Specific Injury or Treatment** *(from_____ to _____)*
- ❑ **X-Ray (check one or both):** ❑ **Films** ❑ **Reports**
- ❑ **Laboratory Results**
- ❑ **Mental Health** *(from_____ to _____)*
- ❑ **Alcohol / Drug** *(from_____ to _____)*
- ❑ **HIV Test Results** *(from_____ to _____)*
- ❑ **Other (specify):** _____

Signature of Patient or Patient's Representative — Date

Signature of Patient or Patient's Representative — Date

Signature of Patient or Patient's Representative — Date

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only: _____

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

Date | Signature of Patient or Patient's Representative | Indicate Relationship (if Signed by Other than Patient)